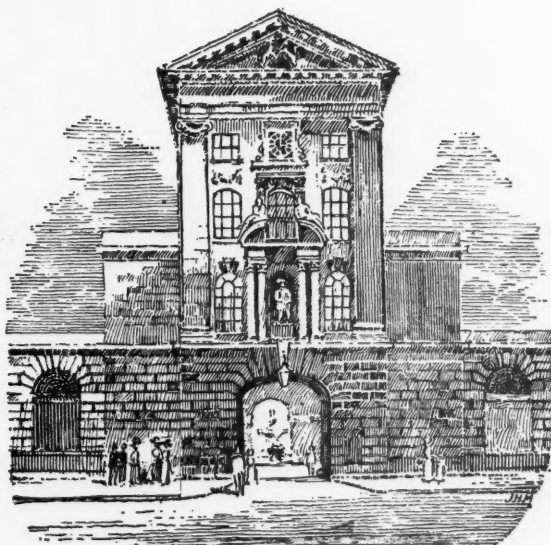


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Medical Lib.



VOL. XXXVII.—No. 1.

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CONTENTS.

	PAGE		PAGE
Calendar	I	Reviews	14
Editorial Notes	I	Recent Books and Papers by St. Bartho- lomew's Men	15
More Medical Notes. By Sir Thomas Horder, Bt.	2	Table of Attendances in the Out-patients' and Special Departments	15
Medical History Taking. By Geoffrey Bourne, M.D., F.R.C.P.	3	Examinations, etc.	16
The Heart as a Temple of Surgical Rashness and Surgical Frigidity. By W. R. Bett, M.R.C.S., L.R.C.P.	7	Changes of Address	16
Writing Up to the Profession. By M. ...	10	Appointments	16
Some Interesting Cases of "Asthma." By H. Simmonds, M.B., B.S.	12	Births	16
Students' Union:		Marriages	16
Rugby Football Club	13	Death	16
Association Football Club	13	Acknowledgments	16
Hockey Club	13	Index to Advertisements	ii
Sailing Club	13		
Swimming Club	14		

INDEX TO ADVERTISEMENTS.

	PAGE		PAGE
Adam, Rouilly & Co.	xviii	Gas Light and Coke Co., Ltd.	xvii
Allen & Hanburys Ltd. Ophthalmoscope	xvi	Genito-Urinary Mfg. Co., Ltd.	x
Alliance Drug and Chemical Co.	xvi	Hall & Sons, Ltd. "Ideal" Boots and Shoes	xi
Books—		Maw, Son & Sons, Ltd. "Tensile" Glove	xx
Adlard & Son, Limited The Fundus Oculi	iii	Medical Sickness, Annuity and Life Assurance Society, Ltd.	xix
Arnold, Edward, & Co. The Puerperium	iii	Millikin & Lawley Microscopes, Instruments, etc.	xviii
Baillière, Tindall & Cox Publications	iii	Northwoods, Winterbourne, Bristol	xviii
Cassell & Co., Ltd. Books for Students	viii	Paripan, Ltd.	x
Churchill, J. & A. Books for Medical Students	ix	Parke, Davis & Co. For Respiratory Infections	xii
Lewis, H. K., & Co. Ltd. Publications	vi, vii	Ronuk	xviii
Livingstone, E. & S. Books for Students	iv	"Round the Fountain"	xiii
Boots Pure Drug Co., Ltd. Insulin	xi	Shepherd, A. Tailor and Hosier	xviii
Budd Bros. Tailors	ii	St. Bartholomew's Hospital Medical College Preliminary Scientific Department	xiv
Clinical Research Department of St. Bartholomew's Hospital	xx	Ditto Scholarships; Bacteriology	xiv
Down Bros. Specialities	xix	Ditto Fellowship Classes; Entrance Scholarships	xv
Evans & Witt Booksellers, Stationers, etc.	xviii	St. Bartholomew's Trained Nurses' Institution	xvii
		Virol	xii

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"Æquamemento rebus in arduis
Servare mentem."

—Horace, Book ii, Ode iii.

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CALENDAR.

- Tues., Oct. 1.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Old Students' Dinner, 7.30 p.m.
- Fri., „ 4.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
- Sat., „ 5.—Rugby Match v. Old Millhillians. Home.
- Mon., „ 7.—Special Subject: Clinical Lecture by Mr. Elmslie.
- Tues., „ 8.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
- Wed., „ 9.—Surgery: Clinical Lecture by Sir Holburt Waring.
- Fri., „ 11.—Prof. Fraser and Prof. Gask on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
- Sat., „ 12.—Rugby Match v. Richmond. Away.
Association Match v. R.M.A. Woolwich. Away.
Hockey Match v. Beckenham II. Home.
- Mon., „ 14.—Special Subject: Clinical Lecture by Mr. Rose.
- Tues., „ 15.—Dr. Morley Fletcher and Sir Holburt Waring on duty.
- Wed., „ 16.—Surgery: Clinical Lecture by Sir Holburt Waring.
- Fri., „ 18.—Sir Percival Hartley and Mr. L. Bathe Rawling on duty.
Medicine: Clinical Lecture by Dr. Morley Fletcher.
- Sat., „ 19.—Rugby Match v. Bristol. Away.
Association Match v. Emmanuel College, Cambridge. Away.
Hockey Match v. Woolwich Garrison. Away.
Last day for receiving matter for the November issue of the Journal.
- Mon., „ 21.—Special Subject: Clinical Lecture by Mr. Just.
- Tues., „ 22.—Sir Thomas Horder and Sir Charles Gordon-Watson on duty.
- Wed., „ 23.—Surgery: Clinical Lecture by Mr. Harold Wilson.
Rugby Match v. Cambridge University. Home.
Hockey Match v. R.N.C. Away.
- Thurs., „ 24.—**Abernethian Society: Address by Sir Leonard Rogers at 8.30 p.m.**
- Fri., „ 25.—Dr. Langdon Brown and Mr. Harold Wilson on duty.
Medicine: Clinical Lecture by Sir Thomas Horder.
- Sat., „ 26.—Rugby Match v. Coventry. Home.
Hockey Match v. Radlett. Away.
- Mon., „ 28.—Special Subject: Clinical Lecture by Mr. Rose.
- Tues., „ 29.—Prof. Fraser and Prof. Gask on duty.
- Wed., „ 30.—Surgery: Clinical Lecture by Mr. Harold Wilson.

EDITORIAL

ON Thursday, October 24th, Sir Leonard Rogers is to deliver the Inaugural Address to the Abernethian Society on "Climate and Disease: forecasting epidemics in connection with Smallpox, Cholera and Plague."

The rise of preventive medicine, rapid as it has been in the past few years, and pregnant as it is with future benefit for mankind, presents some terrifying features to the imagination. The trouble which already surrounds vaccination and vivisection, so essential a part of the antitoxic therapy of the few preventable diseases, is not likely to diminish, and when finally preventive medicine is enthroned, who can but pity the schoolboy of the future? He will purchase dearly his prophylactic metamorphosis into the lean and slipper'd pantaloon; vaccinated, duly Pirquet'd, be-Dick'd, be-Schick'd, and all the rest, he will have good cause to whine. If anything can save him it is the accurate forecasting of epidemics, so that he can be protected only as the need arises.

The forecasting of diseases has still a mediæval flavour, calling to mind the antics of Alcofribas Nasier and his Pantagruelian prognostication "of the Diseases of the Year"; wherein he confesses that "desirous to satisfy the Curiosity of every good Companion, I have tumbled over and over all the Pantarchs of the Heavens, calculated the quadrates of the Moon, hook'd out whatever all the Astrophyles, Hypernephelists, Anemophylaxes, Uranopetes, Ombrophores, and the Devil and all of them have thought." The majority of us, only dimly aware of the considerable advances which have been made in the subject since those times, could gain enlightenment from no one more expert than Sir Leonard Rogers.

* * *

We extend our hearty congratulations to Dr. C. F.

Harris, who has been appointed Physician-in-Charge of the Children's Department.

* * *

Congratulations to Mr. E. T. C. Spooner on his election to a Research Fellowship at Clare College, Cambridge, and to Mr. H. J. Burrows, who has been given the Beaverbrook Scholarship of the Royal College of Surgeons of England for 1930 and 1931.

MORE MEDICAL NOTES.

By Sir THOMAS HORDER, Bt.

ON SEPTIC ENDOCARDITIS.

(1) The most appropriate name for the disease variously termed "infective," "malignant" and "ulcerative" endocarditis is probably the still older one, "septic endocarditis." Objections to each of the alternative adjectives are obvious. It has been advanced that the word "septic" in this connection is not suitable because the lesions present are oftentimes not suppurative. But suppuration is by no means an essential part of either acute or chronic sepsis.

(2) In acute septic endocarditis, a disease which is much less common than formerly, the heart shares in a general infection, the existence of which is generally manifest, and to which are now added the features of an arterial pyæmia. In chronic septic endocarditis, a disease which is much more common than formerly, the state of general infection, if it exists prior to the cardiac involvement, has been latent, so that the patient comes under observation on account of chronic arterial pyæmia from the first.

(3) Septic endocarditis of the right heart occurs under two conditions: (i) Infection of the heart may occur in congenital *morbis cordis*. The course of the disease is usually chronic or subacute and the complication generally constitutes a terminal event. (ii) Infection may occur at the pulmonary or tricuspid orifices in pneumonia or other forms of pulmonary sepsis. The course of the disease is usually acute and probably always fatal.

(4) The chief diagnostic feature of septic endocarditis of the right heart is repeated pleuro-pulmonary infarction. Whenever this occurs the heart should be scrutinized

carefully for signs of infection. The bouts of pleuro-pulmonary inflammation may be very numerous, and the systemic blood-stream, despite the fact that the patient is gravely ill, may be sterile for several weeks.

(5) Every patient who is the subject of valvular disease, and who comes under observation on account of an obscure illness, however mild, should be suspected of septic endocarditis, and submitted to a routine investigation from this point of view. Evidence of the existence of fleeting attacks of the disease prior to the onset of the final one is so definite that this fact leads to a reasonable hope that very early detection of the disease may reduce the gravity of the prognosis as at present taught.

(6) The cardinal signs of septic endocarditis are these: Signs of endocarditis, pyrexia, a positive blood-culture and multiple arterial embolism. Of these, the last-named is the most important, and without evidence of it a diagnosis cannot be made.

(7) Apyrexial periods, not seldom lasting for several days, and very occasionally for some weeks, are not very uncommon in chronic septic endocarditis. They must not be taken of themselves to indicate improvement in the patient's state.

(8) On the other hand, exacerbations of the pyrexia do not necessarily indicate that the patient is losing ground. They are often concomitant with embolic events, and especially with splenic embolism. After such exacerbations the temperature may take a lower range for several days, and during this period the symptoms may show definite remission.

(9) Arthralgic pains, carefully studied, are of definite diagnostic value in chronic septic endocarditis. Three features distinguish them: the suddenness of their onset, the difficulty the patient may have in locating them, and the absence of any recognizable signs of effusion when the affected part is a joint.

(10) A striking difference between rheumatic heart disease and septic endocarditis is the degree to which the myocardium is affected in the two diseases. In the former the disease is notoriously a "carditis"; in the latter it is an "endocarditis vera." This great difference explains why in septic endocarditis the heart maintains its functional capacity in a very striking manner. An interesting example of this is the fact that in septic endocarditis auricular fibrillation rarely occurs.

MEDICAL HISTORY TAKING.

By GEOFFREY BOURNE, M.D., F.R.C.P.

INTRODUCTION.

THE ultimate object of the examination of all patients is cure. In order that this may best be accomplished three ideals are generally held in view, the discovery of the diseased process present, the determination of the rate of advance of such a process, and a decision as to the type of treatment to be undertaken. These are as a rule briefly alluded to under the heads "Diagnosis," "Prognosis" and "Treatment."

In order to avoid a too complacent acceptance of purely academic facts or theories it is as well to have in mind always prognosis, for this forecasting of the course of a disease will necessitate an answer complete in all the other respects. "How will this end?" will be the question before the examiner's mind, though from the patient's point of view successful treatment is the greatest of the three.

Diagnosis is a science, medical practice is an art. The lure of science is apt to make diagnosis loom large in the mind of the doctor, and when he has made his diagnosis, reaction is liable to set in and treatment to take a second place. The illness, however, makes treatment the essential in the eyes of the patient; and treatment is the *raison d'être* of the medical profession. Treatment is either therapeutic or prophylactic.

HISTORY AND PHYSICAL EXAMINATION.

In the elucidation of these problems two methods are employed—history and physical examination.

The first of these is subjective, use being made of the patient's account of what he himself knows, feels or has felt; the second is objective, and comprises all the varying methods of search used by the doctor.

They differ from one another in two important particulars—time-relationship and intimacy.

Physical examination deals with the physical condition upon one day of the patient's life. What physical characteristics are present upon that day may or may not be detected. If the examination be repeated upon some other day the same findings may persist, or new ones may have arisen.

The two days will be analogous to two isolated pictures taken from two distant parts of some lengthy cinematograph reel. What lies between, or what came before, remains hidden.

History, however, gives a continuous record limited only in duration and accuracy by the patient's memory;

and memory—at least the subconscious part—is almost photographic in its exactitude. Everyone, on revisiting some place after months or years, may at a sudden turn of the road or by some trick of local suggestion remember that previously, at that place, he passed in the street individuals having this or that appearance. Thus, if only time and trouble enough be given, a history of very considerable accuracy may be unravelled.

Physical examination deals with the state at one time. History embraces all periods of its development.

The other great difference between physical examination and history is in intimacy.

Physical examination is limited to what can be seen, felt, heard or otherwise physically deduced from the surface of the patient's body. The means at the examiner's disposal range from his fingers to the use of the electrocardiograph, from the ophthalmoscope to the Wassermann reaction; but they are each and all objective. The findings may have nothing to do at all with the disease which is at the moment active and needing treatment. A tabetic with a subacute appendicitis may die or live, to curse the Wassermann reaction that led the too clever doctor to think of gastric crises.

In cases like this an adequate history is the best guide.

History, in contradistinction to physical examination, is subjective. The duodenal ulcer or the inflamed pleura is in direct physical continuity with the patient's brain; there is no intervening link in the shape of test-tubes, stethoscope, or even the examiner's fingers. The sufferer receives from his own diseased area earlier and much more sensitive impressions than does any outside observer. This is the true distinction between symptoms and signs.

Symptoms are the sensations sent to the patient's own brain by his disease; signs are the abnormalities physically detected by another individual.

The priority of history or physical examination as regards importance in diagnosis or prognosis varies greatly with different diseases. Carcinoma of the breast may lurk unheeded until a lump is felt by chance by the doctor, who has been called in to treat an attack of bronchitis. Here the early disease is in a "silent area"; symptoms are absent.

On the other hand loss of appetite, discomfort after food and lassitude may be present and even clamorous for some long time, while the decision hangs in doubt as between tuberculosis of the lung or cancer of the stomach. Only by experience will the relative importance of the two methods of examination in various conditions be learned. It is perhaps true (in most cases) that, as symptoms precede signs, so will history help earlier than will physical examination.

DIFFICULTIES IN OBTAINING A CORRECT HISTORY.

The patient is, as a rule, not a trained observer, and is unable to supply in their proper proportions all the pieces of evidence he may possess relative to his complaint. Some aches, pains or other abnormalities may have been so minor that he has actually forgotten much of what he was at one time well aware. Thus, although he acts as the receptor of all stimuli arising from the diseased area in his body, he is an imperfect recording instrument, and is unable often to supply evidence of the first importance. Even here a careful attempt at taking a complete history may help to unearth some of the buried memories.

The human instrument, besides often being an uncertain recorder, is never exactly duplicated. Individuals react differently to pain, discomfort and worry; and a considerable knowledge of psychology is used consciously or unconsciously in the effort to interpret their complaints. This variation in sensibility is a racial as well as a personal characteristic.

Stimuli that in one case cause intense anxiety or even suffering will in another remain mentally suppressed, the one individual will make the most of his ills, even enhancing them by unconscious repetition; the other will belittle them. Even when suspicious that all is not well, the fear of disease produces in one person silence lest his fears be found to be facts, in another exaggerated statements, lest they be dismissed too lightly. Recognition of this may enable the doctor to assess the evidence in both cases, by means of an estimation of the varying psychologies.

It must never be forgotten that the most loquacious and fussy patient may actually be suffering from a severe disease. Garrulity is not a guarantee of health. Talkativeness has the advantage that perpetual questioning is not so necessary, and the danger of asking leading questions is less. Ideally statements, criminal and pathological, should be spontaneous and not evoked by prompting. The more leading the question the less is the value in evidence of the reply.

Besides this under- or over-sensibility to their own stimuli, some people, often presumably well educated, seem to be quite unable to answer a question. A query as to the earliest appearance of some symptom is answered by a detailed account about the health of a husband. But even here it must be remembered that the health of a tuberculous or syphilitic husband may have a direct bearing upon the health of the patient. The stream of words should be followed, so to speak, to its source, after which a return can be made to the main river, which can then be traced further. Impatience in the examiner is inimical to completeness in the history.

A vital point frequently arises amid a farrago of irrelevant facts.

There remain a few more obvious difficulties in obtaining a history. The patient may be deaf or dumb, or suffering from aphasia. Smaller degrees of deafness may be overcome by placing the stethoscope in the patient's ears and speaking into the mouthpiece. A patient with motor aphasia can frequently comprehend very readily, as indeed may a very weary one. The difficulty may be overcome in either case by framing questions so that "Yes" or "No" can be indicated, by look, nod or word in the reply.

A history can frequently be obtained from a child, but care must be taken to put questions simply. An involved question not only may be unanswerable, it evokes an attitude of shyness and reserve in the answers that follow. Furthermore, a child is always rather too ready to please, and will answer "Yes," if that is presumably what the doctor wants. Questions therefore are much better put in the negative: "You haven't had a pain in your tummy, have you?"

If there has been no pain the child will answer "No"; if there has, an attitude of mild resentfulness against the doctor's stupidity will elicit the reply, "Yes, I have."

If the original question has been put the other way, "Have you had a pain?" the answer "Yes" would frequently be given merely, from the child's point of view, to please the silly man and have done with him as soon as possible.

Similarly, on palpating the abdomen it is wise to say, "That doesn't hurt, does it?" The answer "No" will result everywhere except over the place where it really does, and there a very emphatic "Yes" comes out. The opposite question will be answered in the affirmative every time.

A child is very wishful to please, in order to protect its littleness; similarly it will over-react if in danger of being hurt or of being misunderstood.

Apart from this its evidence is free from the complexities that cloud that of an adult, and should be credited accordingly.

HOW TO TAKE A HISTORY.

History, for practical purposes, is divided into the following sub-headings; these, needless to say, occasionally overlap:

Complaint (a list of the symptoms complained of).

History of present condition.

Past history.

Family history.

The patient's name, address and occupation are first written down with the date of the examination.

COMPLAINT.

This should be a catalogue of the various individual symptoms of which the patient complains. They should, when possible, be the actual words used by the patient.

In asking a patient to supply this list, care should be taken to use a reasonable form of words. "What is the matter?" lays the questioner open to the justifiable retort, "That, doctor, is what I have come to ask you."

"What exactly do you complain of?" or "I want you to tell me the different things that are worrying you," are better. The patient's reply may be "Pain in the stomach," and may threaten to be of considerable length. It is as well at this stage to seize an opportunity to interrupt and ask, "Besides the pain in the stomach what else do you complain of?" The reply may be "Diarrhoea." "What else?" "Blood in the motions." "What else?" "Weakness." "Is there anything else?" "No." "Pain in the stomach, diarrhoea, blood in the motions, weakness. So those are all the things you complain of? You are quite sure there is nothing further?" "Yes, I am."

Having obtained this simple list the examiner can then proceed to the history of the present condition.

HISTORY OF THE PRESENT CONDITION.

Relation to past history.—The history of the present condition dates from the last occasion upon which the patient was in good health, or in his usual state of health.

It is sometimes difficult to divide this from the "past history," especially where the latter contains isolated illnesses, from which recovery was apparently complete, although the sequel proves their relation with the present condition.

Since, however, it is upon the present condition that immediate prognosis usually depends, it is wisest to keep the two things logically distinct. The course of a former attack of syphilis has no bearing at all as regards immediate prognosis upon syphilitic disease of the aortic valve or upon tabetic disease of the spinal cord. Most syphilitics escape both. There are, on the contrary, diseases upon whose severity directly depends the liability to future troubles. Such diseases are often inflammatory, and in them the amount of scar formation varies directly with the virulence of the process. Bronchiectasis or fibrosis of the lung are more likely to follow a prolonged and severe broncho-pneumonia. Here the secondary disease depends upon the severity of the reaction against the primary process. Syphilis is an example of the opposite, for frequently in cases of tabes or general paralysis it is difficult for a patient to

remember his original primary infection in the absence of secondary phenomena.

It is wise, therefore, to place in the past history all definite known illnesses in chronological order; and not to add to the history of the present condition any illness separated definitely from this by a period of good health.

Here it must be remembered that previous illnesses fall under three categories: Firstly, there are those such as scarlet fever, rheumatism, frequent tonsillitis or broncho-pneumonia, upon whose severity depends directly the probability of sequelae such as nephritis, morbus cordis, arthritis or pulmonary fibrosis. Secondly comes the group such as syphilis and amoebic dysentery, where the original severity has no connection with ultimate liability to general paralysis or hepatic abscess.

Thirdly there are illnesses that predispose to others apparently quite unconnected aetiologically with them. Measles and pertussis in children are the frequent immediate precursors of active tuberculosis of the lung, peritoneum or meninges. It would seem in this case that the effect of the primary disease is so to alter the patient's resistance that a latent and hitherto arrested process is given a fatal lease of life.

Scope of the history of present condition.—The history of the present condition is the longest and most intimate account of the patient's illness. Its completeness is only curtailed by the inquirer's knowledge of medicine, though other qualities are of course necessary in addition. A perfectly full history is thus humanly unattainable; but as knowledge grows, so will the value of the history increase.

It attempts, by a collection of all available facts, to define in chronological order the onset of each symptom in turn, its exact character, intensity, duration and relation to any others.

Furthermore, an estimation is made as to the acuteness or virulence of the disease and the resistance of the patient. The resultant of these two factors will indicate the spread of advance, the presence of arrest, or the rate of recovery. This is immediate prognosis. The full prognosis also entails an answer to the questions, "What permanent vital changes will remain after recovery?" "Does this illness expose the patient to any remote sequelae?"

Seeing that a complete, adequate history can be taken only by a person who knows all facts in their true perspective about all diseases, it is obvious that nobody can afford to dismiss an apparently irrelevant piece of information with the words "*nil ad rem*." Such a statement implies at the worst omniscience, and at the best unforgivable arrogance. Every fact must be chronicled and adequately described, prominence naturally being allowed to any whose relation to the disease

is known. Thus only will the science of early diagnosis grow, and thus only will the observer add to his personal value to the community. Leading questions must be avoided.

ON TAKING A HISTORY OF THE PRESENT CONDITION.

The taking of a history should be divided into three portions. At first the patient is asked about, and encouraged to remember accurately, all he can about his individual symptoms in their due order. The date of onset of each symptom should be noted. This should be done in terms of day of the month and year, or alternatively in terms of years ago, months, weeks or days ago. An unforgivable and all too common error—due largely to the laudable desire to quote accurately the patient's words—is to use such phrases as "last Tuesday week," "Sunday night," "the following Friday." What these refer to may be plain at the moment, but the passage of time will soon transform them into a hopeless and impenetrable maze.

Secondly, the questioner, using his expert knowledge of disease, attempts if possible without asking leading questions to obtain answers upon points he knows to be relevant to the disease, which he may by now suspect to be present.

Thirdly, he inquires as to the function of systems other than that of the one apparently diseased.

The first point to be ascertained is the date at which the patient first suffered any unusual symptom. The time-worn opening, "When were you last quite well?" can scarcely be improved upon. It is always wise to reinforce this by some such phrase as "So you never had any trouble at all before that?" This may well excite the reply, "Well, of course, for some months I had not been feeling quite myself," to which is repeated the original question, "Well, when were you last quite well?"

In that way it is generally possible to fix accurately the commencement of the first symptom of illness. Unless care is taken to make certain of the time at which the patient was "last quite well," a false idea may easily be obtained. It is remarkable how often the second move, so to speak, of the gambit will reveal that the original reply was inaccurate. The commonest reason for this is that the patient feels that only a really sharp pain, or a really good big symptom, is worthy of the attention of the medical brain. Doctors, in his mind, and unfortunately sometimes in their own, have too much to do to be bothered with vague pains and minor abnormalities.

There is a second answer which is apt to disconcert the beginner, and that is, "I never have been quite well,

doctor." The correct counter here is, "When were you last in your usual health?" Thus even from those who "enjoy" ill-health a correct starting-point for the history of the present condition may be obtained.

Having thus defined the first symptom, possibly a pain or discomfort, a correct idea must be formed of its nature when it originally appeared. Its character, position, direction of spread, its duration—estimated by the patient specifically in seconds, hours or days; the changes produced upon it by various processes, positional, such as standing, lying and sleeping; occupational and muscular, such as lifting weights, jolting or running; alimentary, such as eating, swallowing and digesting; excretory, such as passing water and defecating, these must all be determined. The effect of treatment by the patient, such as the application of pressure, heat or cold, or by some previously consulted medical man, must be elucidated.

Again, has the symptom progressed or changed at all since its commencement? If so, in what manner? Any intervals of complete remission or of partial relief must be made quite clear.

Having thus obtained an apparently clear account of the first symptom, the others complained of must in their due order be completed. They may, for example, be in all, pain, anorexia, vomiting, constipation and loss of weight.

The anorexia is next dissected. "Has it been permanent since its origin?" "Is it especially noticed after any particular type of food?" That of carcinoma of the stomach is often chiefly in reference to meat. Similarly are treated the vomiting, constipation and loss of weight as fully as possible.

When the list is presumably completed the patient is reminded briefly of the individual symptoms and is asked, "Besides these is there anything else that you have noticed abnormal, or anything else that you think I ought to know?"

This is the first part of the history. It deals with the complaint from the patient's point of view and from that of his subjective sensations.

The second part is the attempt on the part of the trained observer to dig up from the patient's consciousness any other hitherto forgotten facts that, from his knowledge of medicine, or his personal experience, may help to reveal the morbid condition; for by now he will have made a guess at the system or organ chiefly at fault.

For example, if he suspects epilepsy he asks: "Are you subject to fainting attacks?" "When you fall do you know beforehand that you are going to fall or do you find yourself lying on the ground?" "Do you ever hurt yourself when you fall?" "Do you find

that you have passed water when you come to?" "When you have recovered are you as well as before?" The last is an attempt to fish for the answer, without asking a leading question. "No, I have a headache for the rest of the day." The earlier questions will distinguish the abrupt cerebral blow of an epileptic fit from the gradual cutting off of cerebral blood-flow, and therefore of consciousness from the brain, of someone who faints.

The first part of the history could be taken fairly adequately by a person with no especial knowledge of medicine at all.

The only requirements are patience, tact, and a logical brain. The second part is dependent upon previous knowledge. Those who commence to clerk in the wards may thus be expected to deal efficiently with the first part; and in reference to the second they will have some knowledge of anatomy and physiology upon which to base their questions. After every fresh case they will add gradually to their store.

Upon taking over a case for the first time the beginner in medicine should take what history he can. After the questions and physical examination he should write as complete an account as is possible. Upon what he finds and in the light of his own physiological, anatomical and general knowledge he will form an opinion of his own.

Then, and not until then, having made a diagnosis, should he, on his return home at night, open his books. Should the disease have interfered with normal function, his physiological knowledge may explain the manner of this. Failing this, reference to a text-book of medicine will show what signs and symptoms he has omitted to find. On returning to the patient upon the following day a new examination may reveal the presence of those, or, indeed, their continued absence.

By attempting to discover at first all he can for himself, his clinical powers will receive the greater stimulus. Reference to the answer at the end of the book deprives any problem of its educative value. If during three months' work in the ward a dozen cases are dealt with in this manner as texts for reading they will produce mental pictures vivid enough to form the outline of all medical knowledge that follows. Upon them will gradually be grouped a continually growing series of clear impressions.

Personal examination of a patient is a clear-cut experience and the mental picture is sharp as an etching; a clinical lecture is necessarily vague for the mental pictures are all second-hand, and often as vague, vaporous and sleep-compelling as are the visions of any other type of narcosis.

The third part of the history deals with the systems, which may appear superficially to have no connection

directly with that which is disordered. For example, inquiries concerning the nervous, digestive and urinary systems should always be made in cases of heart disease. There are two reasons for this: unsuspected complications may be discovered or suspected ones excluded, and some second and quite unconnected disease may come to light; for the presence of two concurrent diseases is not very uncommon. In either case the discovery may lead to treatment that will remove some of the patient's handicap in his fight against the more serious condition.

Thus in a patient suspected or convicted of tuberculosis of the lungs, questions relative to the gastrointestinal system will be useful. A good appetite is one of the best instruments of successful treatment, or diarrhoea due to tuberculous ulceration of the intestine is one of the first indications of a fatal outcome. Again, questions as to the urinary function may reveal the increased frequency of micturition which is often a first sign of tuberculous disease of the kidney. Should this prove to be advanced and unilateral, surgical treatment may be of value. Attention directed to the cardiovascular system in a phthisical patient may show some degree of anaemia whose progress can be accurately measured by the hæmoglobinometer, thus providing a valuable check upon the progress of the tuberculous process as a whole.

In this case the attempt to obtain a clear idea as to the condition of the systems other than that of respiration may reveal points of the utmost value in diagnosis, prognosis and treatment. Finally, the very asking of systematized questions will bring to the mind much underlying knowledge with regard to the disease in general and its relation to the patient in particular which the questioner was quite unaware that he possessed.

(To be concluded.)

THE HEART AS A TEMPLE OF SURGICAL RASHNESS AND SURGICAL FRIGIDITY.

"The abyss is worth a leap, however wide,
When life, sweet life, is on the other side."



WHAT open-handed benefactor of the profession, Sir John Bland-Sutton, has recently presented to the Library of the Royal College of Surgeons a MS. account in Italian (with translation) by Guido Farina of Rome of his first adventure in heart surgery in March 1896. A man 30 years of age had been stabbed in the heart with a very fine and sharp dagger, the wound penetrating the right ventricle. The surgeon sutured the rent in the heart with silk. The patient died of right-sided broncho-pneumonia, and at autopsy

the heart was found to be perfectly healed. This account which was made known to the English medical world in 1910* forms an important chapter in the fascinating story of the evolution of cardiac surgery.

The human heart by which we live, cynically secure behind the living fortification of chest-wall and pericardium, from time immemorial has been assaulted by love and man with weapons fair and foul. A flood of drugs has been let loose upon it, when lazy to provoke it to activity, to call it back to duty in hours of intoxication. Agents other than drugs have been recruited in the warfare: rest and recreation, diet and climate, and the virtue and vice of psychotherapy.

Since the days of Abner,† who "with the hinder end of the spear smote him under the fifth rib, that the spear came out behind him; and he fell down there, and died in the same place," surgeons have fondled the illusion that injuries to the heart are rapidly fatal.

One day Paré acquainted the scientific world with the tale of a Turin nobleman‡ "who, fighting a duel with another, received a wound under his left breast which pierced into the substance of his heart, yet for all that he struck some blows afterward and followed his flying enemy some two hundred paces," before Death caught him up in the race. Whereupon there went forth such a gasp of astonishment that the dust of ages rose in clouds from the works of Hippocrates, Aristotle, Pliny, and Galen and wellnigh choked the imagination. The conservative profession, having learnt that injuries to the heart need not cause instant death, once more fell asleep. It was left to Farina to open up the field of cardiac enterprise, which surgeons fully exploited during the Great War. A few months after Farina's pioneer operation, Rehn of Frankfurt-am-Main successfully treated a patient who had been stabbed with a kitchen knife.§ Since that time examples of surgical interference with the living heart have multiplied. Ten years after his first successful case, Rehn was able to collect 124 cases in which cardiorrhaphy had been performed with 40 per cent. recovery. We now know that the heart is very tolerant of traumatic insults (Bland-Sutton). The last few years have seen the introduction of operations on the heart of farm animals. In the cow, pieces of wire, knitting needles, meat skewers, and nails may find their way from the rumen through the diaphragm into the pericardium and the heart muscle. The success of their extraction|| is all the more amazing when one

reflects on the conditions awaiting the bovine patient after operation—a cowshed instead of a clean bed; instead of nurses day and night farm labourers whose peaceful life has never been shaken by the Listerian Revolution.

In 1902, Sir Lauder Brunton then aged 58 suggested in a one-page communication to the *Lancet* (i, 352) the possibility of treating mitral stenosis by surgical methods:

"Mitral stenosis is not only one of the most distressing forms of cardiac disease, but in its severe forms it resists all treatment by medicine. On looking at the contracted mitral orifice in a severe case of this disease one is impressed by the hopelessness of ever finding a remedy which will enable the auricle to drive the blood in a sufficient stream through the small mitral orifice, and the wish unconsciously arises that one could divide the constriction as easily during life as one can after death. The risk which such an operation would entail naturally makes one shrink from it, but in some cases it might be well worth while for the patients to balance the risk of a shortened life against the certainty of a prolonged period of existence which could hardly be called life, as the only conditions under which it could be continued might to them be worse than death. I was much impressed by the case of a man under middle age whom I had under my care at St. Bartholomew's Hospital. For no fault of his own, but simply because of his disease, this man was really exiled from his family and one might almost say imprisoned for life inasmuch as he could only live in a hospital ward or a work-house infirmary. Whenever he left the hospital or infirmary with an amelioration of his distressing symptoms and returned home, the exertion brought on an exacerbation and he had to leave home again in a few days to return to the hospital or infirmary. It occurred to me that it was worth while for such a patient to run a risk, and even a very grave risk, in order to obtain such improvement as might enable him at least to stay at home. But no one would be justified in attempting such a dangerous operation as dividing a mitral stenosis on a fellow-creature without having tested its practicability and perfected its technique by previous trials on animals. Accordingly I obtained a licence and certificates a year ago in order to make the necessary experiments, but unfortunately other calls upon my time have not allowed me to do more than make trial experiments of dividing stenosed valves in diseased hearts from the post-mortem theatre and on healthy valves in the hearts of cats, and also to try the proposed operation in the dead animal. It may be some months longer before I can get anything more done, and I therefore think that it may be worth while to write this preliminary note (a subsequent note never appeared), especially as, after all, if the operation is to be done in man, it will be the surgeons who will do it, and they must, of course, make their own preliminary experiments, however fully the operation may be described by others, and each must find out for himself the method which he will employ in each particular case. . . .

"In many experiments made for other purposes I have been astonished at the way in which the heart went on beating, apparently quite unaffected by pulling, compressing, and handling of any kind.

"The good results that have been obtained by surgical treatment of wounds in the heart emboldens one to hope that before long similar good results may be obtained in cases of mitral stenosis."

This courageous and inspired article is spoilt by the scantiness and timidity of the experimental suggestions.

The *Lancet* in a leading article (1902, i, 461) devoted to "this sufficiently heroic therapeutic suggestion" speaks of "difficulties that only the boldest surgeons, with the best-balanced sense of the limitations of their science, could for a moment face. . . . Should our anticipations of failure be proved to be groundless, we shall indeed rejoice to witness an extension of surgery which might be attended with great

* *Brit. M. J.*, 1910, i, 1273, 1309; reprinted in Bland-Sutton, *Selected Lectures and Essays*, 1920. *Vide also Centralbl. f. Chir.*, 1896, xxiii, 1224.

† 2. Sam. ii, 23.

‡ Johnson, Th., *The Works of A. Paré*, London, 1678, 259.

§ *Centralbl. f. Chir.*, 1896, xxiii, p. 1048; *Lancet*, 1897, i, 1306, 1436; *Arch. f. klin. Chir.*, 1907, lxxxiii, 723.

|| *Proc. Roy. Soc. Med.*, 1929, xxii (Sect. Comp. Med.), 19.

alleviation of human suffering. But we can only repeat that the mere suggestion of surgical operation for the relief of mitral stenosis casts a grave responsibility upon Sir Lauder Brunton, and a responsibility that he does not lessen by now leaving it to other workers to prove or to disprove its value."

Brunton's reply to this ill-disguised sarcasm was brief and dignified (i, 547). The temptation to quote from the correspondence appearing in the *Lancet* at this time is too strong. Sir Arbuthnot Lane wrote (1902, i, 547): "This suggestion was made by me to my colleague, Dr. Lauriston Shaw, some years ago

his medical colleagues that such a proceeding is useful. It is possible to do many things that are useless and some things that are harmful."

Dr. D. W. Samways then (1902, i, 548) drew attention to a suggestion which must often have come to the mind of many a physician and which he had thrown out four years previously in a paper on Cardiac Peristalsis (*Lancet*, 1898, i, 927): "I anticipate that with the progress of cardiac surgery some of the severest cases of mitral stenosis will be relieved by slightly notching the mitral orifice and trusting to the auricle to continue its defence."



SIR LAUDER BRUNTON.

(about 1890). . . . I was quite prepared to act as soon as he succeeded in finding a case likely to derive benefit. It was entirely due to his perhaps wise caution that the operation has not yet been performed by me. The method by which I proposed to divide the contracted valve through the ventricle was practically identical with that described by Sir Lauder Brunton. Personally I believe that the operation is feasible and, under certain circumstances, justifiable." Lauriston Shaw, however, had definitely abandoned the idea (1902, i, 619); "Sir Lauder Brunton's chief task is not to show his surgical colleagues that it is possible to enlarge the stenosed mitral orifice, but to persuade

Lauder Brunton was not privileged to see his suggestion rise triumphant above scorn and prejudice. A disappointed man he went down into the silence. There is immortality of the tomb and immortality of the resurrection. The credit of having carried the inspired dream of a sick man into the world of reality belongs to Professor Elliott C. Cutler of the Western Reserve University, Cleveland, Ohio. Cutler, working with S. A. Levine and C. S. Beck, had perfected his technique in numerous and laborious experiments upon animals and had familiarized himself with the working of that delicate organ—the heart. There came to him the opportunity to try his skill on the human subject. His

first patient was a girl of 11 years, bedridden and orthopneic, suffering periodically from such alarming hæmoptysis that she was expected to die daily. Cutler operated in all on seven cases, each presenting the typical signs of mitral stenosis. To each patient the risk involved was carefully explained, and in the first case the family was warned that no similar operation had ever been performed on a living human being. The patients accepted the risk. The first patient survived the operation: her general condition was improved for a time, and there was no recurrence of hæmoptysis. The girl lived for four and a half years a life of restricted activity, interrupted by periodic admissions to hospital for rest in bed. At autopsy the mitral valve was found to be moderately stenosed and thickened. The scar in the left ventricle was well healed. The fate of some of the other patients taught Cutler that "surgery must be reserved for the cases of pure mitral stenosis in which the mechanical obstruction is the dominant feature, and in which the myocardium is relatively intact." In his work Cutler has employed two instruments: the cardiovalvulotome, whose cutting edges are arranged as a shear, and the cardioscopic valvulotome which carries both a light and a knife. Cutler's operative technique was briefly described by Geoffrey Bourne in this *Journal* (1927, xxxv, 22). Cutler* acknowledges his debt to his physiological colleagues who elaborated instruments and methods for creating experimental defects in the heart valves. The operation was performed in this country in 1925 by H. S. Souttar† who approached the mitral valve through the left auricular appendix. Finding only a moderate degree of stenosis and little thickening of the valve, he contented himself with dilating the latter with his finger. The patient made an uninterrupted recovery though there seems to have been little change in the physical signs since the operation. "To hear a murmur is a very different matter from feeling the blood itself pouring back over one's finger. I could not help being impressed by the mechanical nature of these lesions and by the practicability of their surgical relief."

In France, E. Doyen‡ before the War operated on a case diagnosed as congenital pulmonary stenosis which at autopsy revealed an interventricular communication. Tuffier§ in 1913 operated on a young man with marked aortic stenosis which he dilated with his little finger. The patient was reported to be alive and improved in 1924.

* *Boston M. & S. J.*, 1923, clxxxviii, 1023; *Arch. Surg.*, 1924, ix, 689; *ibid.*, 1926, xii, 212; *ibid.*, 1929, xviii, 403.

† *Brit. M. J.*, 1925, ii, 603.

‡ *Presse Méd.*, 1913, xxi, 860, 987; *ibid.*, 1914, xxxv, 282.

§ *La Chirurgie du Cœur*, Cinquième Congrès de la Soc. Int. de Chir., Paris, 1920, Rapports, L. Mayer, Bruxelles, M. Hayez, 1921, 5.

In 1926 Pribram* of Berlin unsuccessfully applied Cutler's technique to a patient suffering from aortic and mitral stenosis.

In the American literature Allen and Graham† record an unsuccessful operation on a case of mitral stenosis in 1922.

The total mortality of the above 12 cases is 83 per cent., the mitral stenosis mortality alone being 90 per cent.

"It is our conclusion that the mortality figures alone should not deter further investigation both clinical and experimental, since they are to be expected in the opening up of any new field for surgical endeavour." (Cutler, 1929.)

In the cool of the evening, Lauder Brunton walks the Square. How his heart would throb with pride and joy if the idea which he suggested twenty-seven years ago for the frowning entertainment of his professional brethren be granted a permanent and honourable place in cardiac therapeutics by this the straitest sect of the Hunterian School of Surgery.

REFERENCES TO CARDIAC SURGERY OTHER THAN THOSE CITED IN TEXT.

ALBUCASIS, *De Chirurgia*, J. Channing, Oxonii, 1778, 445, 447.

PAGET, S., *Surgery of the Chest*, 1896.

BALLANCE, Sir C. A., *Surgery of the Heart*, 1920.

Brit. M. J., 1923, ii, 530; *ibid.*, 1896, i, epitome 81.

Arch. f. klin. Chir., 1867, ix, 571; *ibid.*, 1903, lxxi, 258.

München. Med. Wchnschr., 1902, xlix, 1072.

W. R. BETT.

* *Arch. f. klin. Chir.*, 1926, cxlii, 458.

† *Jour. A. M. A.*, 1922, lxxix, 1028.

WRITING UP TO THE PROFESSION.



HE papers are periodically full of letters from people who protest that plays are grossly inaccurate in matters in which they are experts. But though electrical engineers should protest that the latent period of lighting is not three seconds after the switch is fumbled with, or pianists that actresses should not caress the treble notes of a pianola in response to coy rumblings

in the bass, no one thinks of doubting the most amazing medical manifestations, which unlike mere lighting and soft music, may be turning points in a plot.

The time has come to take a firm stand against the apparently safe anæsthesia that takes place after two dramatic gasps at a handkerchief soaked in chloroform, the convenient and impossible paralyses that attack the "heavy fathers," injections that render men mad, and baths which dissolve dead bodies with no more chemical fuss than a few green fumes. We need an example to be set to the promoters of crook plays, a play which shall satisfy the medical experts. And a sample has been submitted. If the lay public protests it has never heard of tetany, G.P.I. and bronzed diabetes, it must be told firmly (preferably by one of the more spicy and authoritative Sunday papers) that it must accept the rarer manifestations of a known pathology with the same credulity with which it endorses the wilder evidences of a non-existent one.

ACT III.

Darkness. Suddenly a light gleams from left back, illuminating a stone staircase descending to a cellar, whose walls gleam with damp efflorescence, and whose floor is littered with barrels and riverside junk. A doorway, right back, opens directly on to the River Thames. Edward, the detective, and Maisie, the heroine, come down the stairs. They light one candle and Edward hides under the staircase.

MAISIE : Do you think he'll come in answer to my note?

EDWARD (enigmatically) : He may come. He may not come. (*Edward is like that.*)

MAISIE : Why do you pursue him so relentlessly?

EDWARD : If I catch him the Yard will raise my pay, and then—(*he stops, shyly.*)

MAISIE : Yes, Edward?

EDWARD (taking the plunge) : Some time ago a surgeon removed my thyroid gland—only too well. The parathyroids went too. Now all my salary goes in buying parathyroid extract. If only—

MAISIE (changing the subject) : But doesn't he interest you?

EDWARD : Yes. His methods are those of Cutt, a famous criminal, said to be a man of wide education and culture, who disappeared years ago. This man can't be the same, for he is known to be some sort of half-caste. Yet I swear they're the same.

MAISIE (intelligently) : But I don't understand.

EDWARD : Both take a delight in surrounding themselves with queer retainers. We arrested a man called Slowcoach William the other day, and another called Flap-footed Fred. They're safely under arrest and—

MAISIE : Sh—.

(*Another light gleams, and a tall, swarthy, emaciated*

gentleman in evening clothes [immaculate] comes down the stairs. He bows ironically to Maisie and walks to the door, right, opens it. There is a sound of muffled oars and oaths, and two men enter. One shuffles in, his head forward, his arms slightly bent, and a thin trickle of saliva from his mouth gleams in the candle-light. The second boldly, if erratically, stamps into the room. The gentleman speaks.)

Bill, Fred, are you ready?

BOTH : Yes, Chief.

THE CHIEF (to the hidden Edward) : You may come out now.

EDWARD (blinking a little) : There has been a mistake.

THE CHIEF (grimly) : There has.

(*At his signal the two men set on Edward. A wild fight ensues, in which Edward momentarily gets the better of his two opponents. Picking up a handy crowbar he yells at Slowcoach Bill, "Look there," pointing to the river door. Bill slowly turns to see what is there, and receives a violent kick behind, whereupon he rapidly festinates out of the door. A dull splash is heard, and Edward overturns the candle. In the dim light Fred is seen stamping helplessly about on a wide base, and succumbs to a smack from the crowbar. The Chief calmly re-lights the candle. Edward is seen lying panting on the stairs, helpless in the grip of a violent tetanic spasm.*)

THE CHIEF (propping him considerably against the wall) : Enjoy your spasm before I kill you. (*He tilts his chin up and shakes his head reminiscently.*) Ah, I made pretty collar incisions in those days.

EDWARD (as well as his larynx lets him) : Then you did it? Ah, Cutt, you swine!

THE CHIEF : Now, little girlie, don't be afraid. Tell me where the papers are and — (*Big Ben strikes 10 p.m. off.*) That reminds me. (*He takes out a syringe, fills it, and injects himself.*)

MAISIE (with intolerable scorn) : Drug fiend!

THE CHIEF (wincing and says hotly) : It isn't. (*With pathos.*) It's insulin.

MAISIE (with womanly logic) : It's the same thing.

(*Meanwhile Edward has rolled over and is busily licking the calcium salts from the cellar wall. As the Chief advances upon Maisie he springs up, whirling his crowbar, and chases the Chief over the barrels till he is exhausted. He stands, about to surrender, and suddenly falls paralysed to the ground.*)

EDWARD : Aha! You see your insulin has proved to be no use—(*he pauses for breath*)—whatsoever.

(*He stoops and takes something out of the Chief's pockets. Police descend the stairs at his whistle, and having carried off the recumbent Fred, who is offering them cheques for £10,000 on the Bank of Borneo, return to force the hemiplegic gentleman up the stairs.*)

(Edward and Maisie are turning towards one another when the Sergeant speaks.)

SERGEANT: 'Ere, 'ow are we to shift this blighter, sir?

EDWARD (one arm round Maisie, holds out the stuff he took from the Chief's pocket): The answer is a lump of sugar.

And as the snarling and now hyperglycæmic Chief is frog-marched up the stairs, Edward turns and says to Maisie: And I, likewise, need something sweet.

[Curtain.]

M.

SOME INTERESTING CASES OF "ASTHMA."



ASTHMA can be defined as any form of dyspnoea of expiratory type occurring in paroxysms.

The following cases of asthma, described from a general practitioner's point of view, illustrate the difficulties in diagnosing the various types and of the treatment of this very distressing condition:

CASE 1.—M. S—, male, æt. 17. Had scarlet fever when a child, and since then had persistent albuminuria. Never suffered from any chest trouble until one very foggy night, when he had a severe attack of dyspnoea—sitting up in bed panting for breath, chest full of wheezing rhonchi, particularly expiratory. He was diagnosed as a case of bronchial asthma and an injection of morphia gr. $\frac{1}{4}$ with atropine gr. $\frac{1}{100}$ was given. He was much better the next morning, but had another severe attack of dyspnoea a week later, necessitating another injection of morphia. He was not very much relieved after this injection, and so was sent to the hospital. There he was diagnosed as a case of renal asthma, and after about three months he died in hospital.

CASE 2.—Mr. Z—, æt. 50. Was seen complaining of a persistent cough and loss of weight. Fine crepitations were discovered in the right base and he had a temperature of 100° F. Pulmonary tuberculosis being suspected he was sent to a chest hospital, but no definite diagnosis was made. One morning, while yet in bed, he had a sudden and very severe attack of dyspnoea, lying in bed panting for breath, markedly pale and sweating, lips cyanosed and with a rapid pulse. The chest was full of wheezing rhonchi. Coronary thrombosis was diagnosed, and morphia gr. $\frac{1}{4}$ with strychnine gr. $\frac{1}{100}$ were injected subcutaneously. After a few hours the attack abated somewhat. A very bad prognosis was given and he was kept in bed for a fortnight. He was then seen in consultation with a physician, who discovered a dull patch in the right lower lobe, but while he was being examined the patient had an extraordinarily severe attack of dyspnoea. He became pale and sweaty, with blue lips and with a very anxious expression on his face. His pulse became irregular, was easily compressed and was over 120 to the minute. An immediate injection of 7 minims of liquor adrenalin (1 in 1000) and of morphia gr. $\frac{1}{4}$ was given. A diagnosis of pneumonia (? T.B.) with acute right heart failure was made and he was kept in bed for a few days, during which time he was given digitalis *per os* and injections of strychnine gr. $\frac{1}{100}$ night and morning. When his condition had improved somewhat he was sent to the Hospital. He was there for nearly two months, and despite the fact that his chest was X-rayed nothing definite was found. He had only been discharged from Hospital about a week when he had another very severe attack of dyspnoea. A very dull patch was found in the right base of his lung extending up to the level of the scapula. A hypodermic of morphia gr. $\frac{1}{4}$ and strychnine gr. $\frac{1}{100}$ was given, and he was sent back to the Hospital, where he is improving gradually.

CASE 3.—Mr. B—, æt. 55. Was quite well until one day while out walking he felt a "discomfort" in the left side of his chest, accompanied by severe shortness of breath. He managed to get to his house, where he was seen panting for breath, very sweaty, his lips blue, while the rest of his face had a yellowish tinge. The pulse was hardly palpable, rapid and irregular. The area of cardiac dullness was slightly enlarged. The chest was full of *râles* and rhonchi, the heart-sounds being inaudible. A diagnosis of coronary thrombosis was made, and stimulants and morphia gr. $\frac{1}{4}$ were given. For the following few weeks he was kept quietly in bed, but despite this he had repeated attacks of dyspnoea necessitating more injections of morphia. He was then seen in consultation with a physician, who confirmed the diagnosis, and gave an intramuscular injection of 6 minims of liq. adrenalin (1 in 1000). This seemed to have a markedly beneficial effect on the patient. The blueness of his lips disappeared, his dyspnoea improved and the expiratory rhonchi in his chest were not so marked. The injections of adrenalin were then repeated night and morning, but as there was no further improvement he was transferred to hospital, where, after some more attacks of dyspnoea, he died suddenly in his sleep.

CASE 4.—Mrs. B—, æt. 59. Was quite well until a year ago, when she had a sudden and severe attack of dyspnoea in the middle of the night. She was seen sitting up in bed panting for breath, very pale and sweaty; hands cold; pulse slow; the chest full of wheezing rhonchi and with a very anxious expression on her face. There was no albuminuria. She was thought to have bronchial asthma, and $\frac{1}{4}$ gr. of morphia was injected. She was also given tr. bellad. and tr. stramonii, combined with expectorants, and was greatly relieved. During the following six months she had repeated attacks of dyspnoea, always at night, and which were only relieved by morphia. Owing to the attacks becoming more and more frequent she was sent to the hospital, where a diagnosis of renal asthma was made. She died in hospital a few weeks later.

CASE 5.—Mr. G—, æt. 54. Had suffered from severe bronchitis and pharyngitis for some years past. Was of a very nervous disposition and was a very heavy smoker. Two years ago he coughed up some blood. His chest and sputum were examined, but beyond severe bronchitis nothing else was discovered. Four months ago he was seen complaining of a cough. Temperature and pulse were normal, but the chest was full of *râles* and rhonchi. A week later he complained of shortness of breath, this being thought to be due to bronchial asthma. He was kept in bed and given pot. iod. and tr. stramonium, but with no improvement. By that time his temperature had gone up to 100° F. He was seen in consultation, and a diagnosis of bronchitis and asthma following influenza was made and injections of adrenalin for the attacks were suggested. There was no improvement in his condition, however, the dyspnoeic attacks coming on whenever the patient moved in his bed. One foggy night he had a persistent and very severe attack of dyspnoea, which lasted the whole night through, sitting up in bed, pale and sweaty, and gasping for breath. He was given hot coffee to drink and intramuscular injections of adrenalin were given, but with no relief. Morphia gr. $\frac{1}{4}$ was then injected, with only slight relief as a result, so that two hours later another $\frac{1}{4}$ gr. had to be given. This relieved the patient, but after a few hours' sleep the dyspnoea returned. Morphia and adrenalin had to be injected every night in order to give the patient some rest, but while about to inject the morphia on the fourth evening after the severe attack of dyspnoea the patient collapsed. Artificial respiration was tried, strychnine, adrenalin and camphor were injected, but after a few feeble beats his heart stopped beating altogether.

CASE 6.—Mr. S—, æt. 71. Had suffered from bronchitis for a number of years. On the same very foggy night as mentioned in the last case he had an extraordinarily severe attack of dyspnoea, so much so that the noise he made when he breathed could be heard from the ground floor. The chest was full of rhonchi. He refused to have any kind of injection and was given pot. iod. and tr. stramonium in an expectorant mixture. The next morning he was out of bed quite relieved.

CASE 7.—Mr. R—, æt. 66. Was quite well until three years ago, when he had bronchitis with slight oedema of the legs. He improved with medicine, but he always had attacks of dyspnoea whenever the weather was at all foggy. While on a holiday by the seaside he had a sudden and severe attack of dyspnoea, which, despite all kinds of medicine, persisted. He was then brought up to London and was diagnosed as a case of cardiac asthma. All kinds of injections were given, including adrenalin, caffeine and ephedrine, but with no relief. Morphia was not given immediately, as it was not thought advisable to do so as the chest was full of *râles* and rhonchi and the patient an old man. Ultimately morphia gr. $\frac{1}{4}$ had to be injected,

as the patient was getting exhausted through lack of sleep. After a few hours' sleep he felt much better, but from time to time had further attacks of dyspnoea. Suddenly, in an attack, his pulse and respirations became very rapid, he lost consciousness and died within a few hours after having been in bed for over six weeks.

It will be seen that in the cases cited all the patients had râles and rhonchi in their chests, making it difficult to diagnose the type of asthma. As regards treatment, morphia was the only drug that was of any real service.

H. SIMMONDS.

STUDENTS' UNION.

RUGBY CLUB.

It is hoped that all freshers who play rugger will continue to play at the Hospital this season, as fixtures have been arranged for six sides, and their support will be badly needed.

A Freshers' trial match will be held on *Wednesday, October 9th*, at Winchmore Hill, and we shall be glad to see all who can turn up.

So far the ground has been too hard to have any trial games, and we have had to content ourselves with training in tennis shoes.

It has been most encouraging to see such good attendances, and it is evident not only that the "1st," but that the "A" has every prospect of a successful season, especially in the Junior Hospital Cup, which they won so handsomely last year from Guy's.

J. M. J.

ASSOCIATION FOOTBALL CLUB.

ANNUAL GENERAL MEETING.

The Annual General Meeting of the Association Football Club was held on May 7th, 1929. In the absence of the President, Sir Charles Gordon-Watson, Mr. E. G. C. Darke took the chair.

The following officers were elected:

President.—Sir Charles Gordon-Watson.

Vice-Presidents.—Mr. R. Foster Moore, Dr. A. E. Gow, and Dr. W. H. Hurlley.

Captain.—C. A. Keane.

Hon. Secretary.—A. W. Langford.

Captain 2nd XI.—G. H. Brookman.

Hon. Secretary 2nd XI.—H. J. Roache.

Captain and Hon. Secretary 3rd XI.—S. Barigrasser.

Committee.—A. Caplan, R. G. Gilbert, W. Hunt.

The following were awarded Honours for the season 1928-29: J. H. Watkin, R. McGladdery, G. R. Morgan, A. W. Langford, C. A. Keane, J. R. Crumdie, A. M. Gibb, I. E. Phelps, W. J. Burgess, W. Hunt and R. A. Sykes. C. A. K.

HOCKEY.

We extend a hearty welcome to all Freshmen who wish to play hockey this season, and we ask them to sign the sheet on the notice-board in the Abernethian Room. On Saturday, October 5th, there will be a trial game at Winchmore Hill, details of which will be posted on the board.

Before dealing with the prospects for this season, let us review last season briefly. The 1st XI did splendidly, due to the example and leadership of Church. They won 19 games, drew 3 and lost 3. In the Inter-Hospital Championship they were runners-up, losing to U.C.H. by 1 goal to nil.

The 2nd XI were not quite as successful as they have been during the last few seasons. In the Junior Inter-Hospital Championship they were runners-up. The 3rd XI were handicapped by the poverty of their fixture list, but it has been improved for this season, and steps have been taken to bring it up to normal for future seasons.

What are the prospects for this season? There are several vacancies in the 1st XI to be filled, mostly in the forward line; and I think we shall be able to build up a line which will carry us through the "Cuppers" at the end of next term. There is one vacancy in the half-back line, and there are several promising candidates for the position. So the prospects on the whole are rosy.

P. M. W.

SAILING CLUB.

Small boat sailing amongst medical students is becoming increasingly popular, judging by the large and enthusiastic attendance at the Inter-Hospital Regatta held at Burnham-on-Crouch under the flag of the Royal Corinthian Yacht Club last month, which is reported below.

So much so that a word or two about the facilities offered to medical students of the London teaching hospitals might be in season at this, the beginning of the academic year.

There is a United Hospitals Sailing Club which keeps seven 14-foot dinghies and one 21-foot half-decker at Burnham-on-Crouch for the use of members. This club was started in 1924, when it had one dinghy, and the progress it has made is obvious from the size of its fleet at present. There are two cups to be competed for, one presented by Mr. Harold Wilson for single-handed dinghy racing, the other, the Sherren Cup, to be competed for by a crew of four from each hospital.

Races have been arranged for the Club every Bank holiday week-end by the Burnham clubs, and a race every day of Burnham week, which is held during the last week in August.

Dr. Lander, a Bart.'s man in practice in Burnham, owns a four-ton Bermudan rigged sloop, with two berths, which he has very kindly offered to lend to any Bart.'s members any week-end when he is not using it himself, provided they will take full responsibility. Applications to be made through the Secretary of the Bart.'s Sailing Club.

Strenuous efforts are being made this autumn to provide a clubhouse or headquarters of the club at Burnham. This would take the form of a floating hull or a hut on shore with accommodation in the form of ten or twelve bunks in it. It is confidently anticipated that before the next season opens at Easter, 1930, something of the sort will be in existence.

The Autumn General Meeting, to be followed by the Annual Dinner, will be held in November, the precise date to be announced later. It is hoped that large numbers will turn up. Anyone wishing for information about the Sailing Club should apply to the Secretary, who will be pleased to help them in any way.

INTER-HOSPITAL REGATTA.

The Inter-Hospital Regatta was held at Burnham-on-Crouch on September 14th and 15th. The Royal Corinthian Yacht Club very kindly took charge of the races and made all members of the hospitals present honorary members for the week-end.

Bart.'s are very fortunate in having such enthusiastic flag-officers, for the Commodore, Dr. Dudley Stone, arrived on Friday evening and stayed till late on Sunday evening, and both Dr. Harris and Dr. Cullinan, the Vice- and Rear-Commodores, arrived on Saturday in time to see the race for the Wilson Cup.

The final for the Wilson Cup was sailed off on Saturday afternoon. As there was only a light south-westerly air the course was shortened to once round the "Old Roach" course. The only Bart.'s representative left in for the final was F. T. J. Hobday, the other three competitors, C. F. Watts, J. T. Rowe and J. Hopton, being unfortunate in coming second in each of their heats sailed earlier in the season. The race resulted in Bart.'s, the holders, losing to C. Harvey, of the Middlesex, F. Gibson, of the London, second, and F. T. J. Hobday, of Bart.'s, third.

In the evening an entertaining dinner was held in the Corinthian Club, at which a large number of Hospital members were present. Dr. Cullinan added greatly to the enjoyment of the evening by performing some very clever conjuring tricks.

The Sherren Cup was sailed off on Sunday. There were two races, each twice round the course, thus making four rounds, each member of a crew of four to take the tiller once round the course. Owing to the prevailing conditions the course was a shortened "Old Roach" course. The first race started in a very light westerly air at 10.15 a.m., Bart.'s being represented by V. C. Thompson and J. Hopton. The wind held until the beat up the Crouch started, when it dropped, and a flat calm prevailed for two hours. Those boats in shallow enough water kedged. Bart.'s were unfortunate in being caught in deep water and were rapidly carried back past the Spit Buoy by a strong ebb tide, so gave up and rowed in. At 2 o'clock a light easterly wind sprang up and the race was signalled when one round was completed. The second race was sailed over a very much shortened course, and resulted in a dead-heat between the London and Middlesex; Bart.'s, who were represented by C. F. Watts and F. A. Richards, were disqualified owing to fouling a mark. The tie was sailed off at once and resulted in Middlesex winning the Sherren Cup.

No account of this season's activities would be complete without some mention of W. F. Richards, one of our ablest helmsmen, and the holder of the Wilson Cup, who has been seriously ill. The Club extends its sympathy, and looks forward to seeing him at the helm once again.

J. HORTON,
Hon. Sec.

SWIMMING CLUB.

The Club has had no fixtures since July, but it is not too early to begin thinking about next season. The team will in all probability present several gaps next May, and these must be filled as soon as possible in order that the newcomers may play in several fixtures which will be arranged during the winter.

This article is, therefore, mainly addressed to freshmen coming up this term who are, or at any time have been, associated with the aquatic world. For their benefit we might state a few facts: The Club mainly plays water polo, but takes part in swimming events as they arise. Club nights during the summer are on Fridays at 8 o'clock at Pittfield Street Baths, and during the winter as may be arranged. Lastly, we won the Inter-Hospital Water Polo Cup for the first time this year, and we want all the support we can get, not only to achieve this again, but also to carry off the Swimming Cup as well next year.

May we earnestly implore all new swimmers to turn up without fail at the Freshers' Tea, and communicate with the Secretary?

J. F. FISHER,
Hon. Sec.

REVIEWS.

RADIUM AND ITS SURGICAL APPLICATIONS. By H. S. SOUTTAR, D.M., M.Ch.(Oxon.), F.R.C.S.(Eng.). (London: William Heinemann, Ltd., 1929.) Pp. 60. Illustrated. Price 7s. 6d. net.

This little book appears at a critical period in the history of radium treatment. The research work of physicists and clinicians in the past few years has created an interest in the possibilities of radium therapy which is spreading rapidly beyond the medical profession. The clinicians have satisfied themselves that in radium they possess a powerful weapon to combat cancer—how powerful it is impossible as yet to say. The layman, taking the guarantee of the expert's word, starts to set in motion financial machinery designed to provide radium to meet the demands of the profession. He will soon require a return for his money, and the medical man must see to it that his part of the bargain is fulfilled.

The conscientious practitioner will want to know how radium works, how to select cases suitable for its use, how it is to be used, and what is to be expected from it. It behoves those having special knowledge to instruct their brethren, and to be circumspect in their speech, especially in regard to end-results.

Mr. Souttar can speak with the authority of one who is familiar with the action and uses of radium. And though a book of this size cannot give sufficient detail to be a real guide to the uninitiated, yet it sets forth in a clear and readable form some of the essential points in regard to the physical properties of radium and the methods of its application. The portions of the work which call for severe criticism are those in which illustrative cases are quoted. In many cases the diagnosis has been made on clinical grounds alone, unconfirmed by pathological investigation, and the accounts are illustrated by drawings and diagrams which are unconvincing as evidence of the nature or magnitude of the tumour. Isolated cases are quoted without any facts to show whether or not the response has been what one may expect as a rule from the radiation of such a tumour.

That radium sometimes acts like a charm nobody will deny; but to quote cases of tumours which have "vanished" dramatically will neither instruct the novice nor convince the sceptic. We feel that there is in this book an element of optimism which may be misleading, and a suggestion of "cancer-cure" which may be difficult to justify in our present state of ignorance.

HERMAN'S DIFFICULT LABOUR. Seventh Edition. Revised by CARLTON OLDFIELD, M.D., F.R.C.S., F.R.C.P. (London: Cassell & Co., Ltd., 1929) Pp. 560. Price 16s. net.

In this edition Mr. Oldfield has made a number of changes and additions to Herman's excellent book, and yet has maintained the general style and arrangement of the original writer. The chapter on the Mitigation of Pain in Labour is perhaps too short and

condensed; many private practitioners would appreciate more detailed information. Puerperal sepsis is much before the eyes of the public and the profession at the present time, and the advice as to the relative circumstances under which rectal or vaginal examinations should be carried out is well worthy of consideration. One or two small points of criticism present themselves. Forceps are often applied in the lithotomy position, but there is no description of the application in this position. Four pages are given to the discussion of interlocked twins, which are, as the author states, "excessively rare." With regard to the technique of suture of the uterine muscle after the extraction of the child in Casarian section, it would seem more complete if silk worm gut also were mentioned, as it is the suture used (in lieu of catgut) by many operators. Eight excellent X-ray plates serve to remind the reader of the increasing use of radiology in midwifery, and the mention of ultra-violet light treatment for osteomalacia is of interest.

If perhaps the book is too detailed for the student at the commencement of his study of midwifery, it will certainly be of great assistance to those who require more than is contained in the smaller treatises, to resident midwifery assistants, and to general practitioners for reference, when called in to deal with difficult labour.

THE DISEASES OF CHINA. By JAMES L. MAXWELL, M.D., B.S. Second Edition. (Shanghai: A.B.C. Press, 1929.) Pp. ix, 530, with 176 illustrations. Price 20s. net.

The first edition of this book appeared under the joint authorship of Drs. Jefferys and Maxwell. Owing to the retirement from China of the former, the whole task of bringing the present edition up to date has devolved upon the present author. The advances which have taken place in all branches of medicine within the last few years have necessitated a very considerable alteration in the form and contents of most of the chapters with the exception of that on tumours. The object of the author is to assist physicians in China, particularly those in more or less isolated situations, and this object is adequately achieved.

The material consists largely of an expression of the author's personal experience, combined with copious references to the work of other observers scattered throughout the whole of China. The resultant mixture makes interesting reading and, from the clinical point of view, contains much information of value, although, in a future edition, we hope to find a fuller and clearer description of the pathological findings in the more definitely Oriental diseases.

The illustrations are, on the whole, well reproduced.

PHYSIO-THERAPY IN GENERAL PRACTICE. By E. BELLIS CLAYTON, M.B., B.Ch.(Cantab.). (London: Baillière, Tindall & Cox, 1928.) Pp. x, 231. Figs. 53. Price 12s. 6d. net.

In the medical curriculum no provision is made for the teaching of physio-therapy, yet this is an item of considerable importance in the proper treatment of most medical and surgical conditions. The wide scope of such therapy is well shown in this extremely useful book.

The second edition has been enlarged and made more complete by the inclusion of a chapter on ultra-violet light, radiant heat, diathermy and other forms of electrical treatment. The first two chapters deal with massage, exercises and electrical treatment in general, and the remainder of the book with the appropriate physio-therapeutic treatment of various injuries and diseases. In the treatment of empyema after rib-resection the author advises the commencement of exercises on the day after operation. This would probably help to prevent the bronchiectasis and deformity of the chest which frequently follow.

The terms used by the medical gymnast sound strange to the uneducated ear, and it is fortunate that a glossary is provided. The exercises are illustrated by excellent photographs. To those who wish to extend their range of therapeutics this is a book which can be thoroughly recommended.

HANDBOOK OF BACTERIOLOGY. By J. W. BIGGER, M.D., F.R.C.P.I. Second edition. (London: Baillière, Tindall & Cox, 1929.) Pp. xvi, 435. Illustrated. Price 12s. 6d. net.

This edition is a worthy successor of the first, and maintains its use as a short text-book of bacteriology, supplying in a clear manner the essentials of the subject, without including those elaborations of interest only to the expert.

Two new chapters have been added to the book—one on the rôle of bacteria in the body in health, and the other on the classification

of bacteria. The latter, in view of the various classifications at present in use, is valuable for reference.

A large amount of recent work in bacteriology has been included, e.g. bacterial variation and serology, streptococci, including *S. scarlatinae*, food-poisoning bacilli and yellow fever. The chapter on diseases due to filterable viruses contains much useful information difficult to find elsewhere.

The book is to be especially recommended as a manual to be read whilst taking a practical course in this subject for the final M.B. examinations.

RECENT BOOKS AND PAPERS BY ST. BARTHOLOMEW'S MEN.

ANDREWES, C. H., M.D. "Virus III in Tissue Cultures. I. The Appearance of Intracellular Inclusions *in vitro*." *British Journal of Experimental Pathology*, April, 1929.

— "Virus III in Tissue Cultures. II, Further Observations on the Formation of Inclusion Bodies. III, Experiments Bearing on Immunity." *British Journal of Experimental Pathology*, August, 1929.

APPLETON, A. B., M.A., M.D., M.R.C.S., L.R.C.P. "On the Morphology of the Cervico-costohumeral Muscle of Gruber." *Journal of Anatomy*, July, 1929.

— (and GHEY, P. H. R.). "An Example of the Cervico-costohumeral Muscle of Gruber." *Journal of Anatomy*, July, 1929.

BATTEN, LINDSEY W., M.B., M.R.C.P. See SIMPSON and BATTEN.

BRAMBRIDGE, C. V., F.R.C.S.(Edin.). "Some Remarks on the Relation between Rainfall and Prevailing Diseases in Nairobi." *Kenya and East African Medical Journal*, June, 1929.

BUCHANAN, Sir GEORGE S., C.B., M.D., F.R.C.P. "Collective Public Effort in Dealing with Cancer." *Report International Conference on Cancer*, London, 1928.

BURROWS, HAROLD, C.B.E., M.B., F.R.C.S. "The Induction of Inflammation in the Treatment of Malignant and other Local Diseases." *Lancet*, September 21, 1929.

CANTI, R. G., M.D. "The Relationship of Intensity of Radiation and Time." *Report International Conference on Cancer*, London, 1928.

COCHRANE, R. G., M.D., M.R.C.P., D.T.M.&H. "The Use of Alepol in the Treatment of Leprosy." *Leprosy Notes*, April, 1929.

— "Leprosy Relief in Cyprus." *Leprosy Notes*, July, 1929.

CORSE, H., F.R.C.S. "Leiomyoma Cutis Multiplex." *Proceedings of the Royal Society of Medicine*, August, 1929.

COYTE, RALPH, M.B., B.S., F.R.C.S. "Stone, weighing twelve ounces, removed from Right Kidney." *Proceedings of the Royal Society of Medicine*, August, 1929.

— "Skiagram of Large Stone, three inches in length, removed from Right Ureter." *Proceedings of the Royal Society of Medicine*, August, 1929.

— "The Treatment of Hernia in Children." *Clinical Journal*, September 11, 1929.

DALTON, C. H. C., M.A., M.D., M.R.C.S., D.M.R.E. "Arsenical Poisoning, with Special Reference to Treatment with the Galvanic Current." *British Medical Journal*, August 17, 1929.

DONALDSON, MALCOLM, F.R.C.S. "The Advantages of Radiation in the Treatment of Cancer of the Cervix Uteri." *Report International Conference on Cancer*, London, 1928.

FINZI, N. S., M.B., D.M.R.E. "The Latent Period." *Report International Conference on Cancer*, London, 1928.

FRASER, FRANCIS R., M.D., F.R.C.P.(Edin.). "The Place of Human Physiology in the Training of Medical Students." *British Medical Journal*, August 31, 1929.

GORDON-WATSON, Sir CHARLES, K.B.E. "Radiation in the Treatment of Cancer of the Rectum." *Report International Conference on Cancer*, London, 1928.

TIMES OF ATTENDANCES IN THE OUT-PATIENTS' AND SPECIAL DEPARTMENTS.

	Monday.	Tuesday.	Wednesday.	Thursday.	Friday.	Saturday.
Medical Out-patients	Dr. Graham 9 to 10 a.m.	Dr. Hilton 9 to 10 a.m.	Dr. Hinds Howell 9 to 10 a.m.	Dr. Gow 9 to 10 a.m.	Prof. Fraser 9 to 10 a.m.	Dr. Geoffrey Evans 9 to 10 a.m.
Surgical Out-patients	Mr. Dunhill 9 to 10 a.m.	Mr. Girling Ball 9 to 10 a.m.	Mr. Vick 9 to 10 a.m.	Prof. Gask 9 to 10 a.m.	Mr. Roberts 9 to 10 a.m.	Mr. Keynes 9 to 10 a.m.
Diseases of Women	Dr. Shaw 9 to 10 a.m.	—	Dr. Donaldson 1.30 to 2 p.m.	Dr. Donaldson and Dr. Shaw 1.30 to 2 p.m.	—	Dr. Shaw 9 to 10 a.m.
Orthopædic Department	Mr. Elmslie 1 to 1.30 p.m.	—	—	Mr. Elmslie 1 to 1.30 p.m.	—	—
Throat and Nose Department	Mr. Bedford Russell 1 to 1.30 p.m.	Mr. Rose 9 to 9.30 a.m.	—	Mr. Bedford Russell 9 to 9.30 a.m.	Mr. Rose 1 to 1.30 p.m.	—
Aural Department.	Mr. Sydney Scott 1 to 1.30 p.m.	Mr. Just 9 to 9.30 a.m.	—	Mr. Sydney Scott 9 to 9.30 a.m.	Mr. Just 1 to 1.30 p.m.	—
Ophthalmic Department	Mr. Rupert Scott 1 to 1.30 p.m.	Mr. Foster Moore 1 to 1.30 p.m.	—	Mr. Rupert Scott 1 to 1.30 p.m.	Mr. Foster Moore 1 to 1.30 p.m.	—
Skin Department.	—	Dr. Roxburgh 9 to 10 a.m.	Dr. Roxburgh 9 to 10 a.m.	—	Dr. Roxburgh 9 to 10 a.m.	—
Children's Department	Dr. Harris 1 to 1.30 p.m.	—	—	—	Dr. Harris 1 to 1.30 p.m.	—
Dental Department	Mr. Hankey 9 to 10 a.m.	Mr. Coleman and Mr. Hankey 9 to 10 a.m.	Mr. Cowan 9 to 10 a.m.	Mr. Hankey 9 to 10 a.m.	Mr. Fairbank and Mr. Cowan 9 to 10 a.m.	Mr. Cowan 9 to 10 a.m.
Electro-Therapeutics	Dr. Cumberbatch 1.30 p.m.	Dr. Cumberbatch 1.30 p.m.	—	Dr. Cumberbatch 1.30 p.m.	Dr. Cumberbatch 1.30 p.m.	—
X-Ray Department	Dr. Stone 9.30 a.m. Dr. Finzi and Dr. Stone 1.30 p.m.	Dr. Stone 9.30 a.m. Dr. Finzi and Dr. Loughborough 1.30 p.m.	Dr. Loughborough 9.30 a.m.	Dr. Loughborough 9.30 a.m. and 1.30 p.m.	Dr. Finzi 9.30 a.m. and 1.30 p.m.	—

- HILL, NORMAN H., M.D., M.R.C.P. "The Clinical Significance of Jaundice in the Newly Born." *Clinical Journal*, August 7, 1929.
- HORDER, Sir THOMAS, Bart., K.C.V.O., M.D., F.R.C.P. "A Consideration of Cancer Cachexia." *Report International Conference on Cancer*, London, 1928.
- HUME, J. BASIL, M.B., F.R.C.S. "The Results of Lead Treatment at St. Bartholomew's Hospital, London." *Report International Conference on Cancer*, London, 1928.
- KEYNES, GEOFFREY, M.A., M.D., F.R.C.S. "Radium Treatment of Carcinoma of the Breast." *Report International Conference on Cancer*, London, 1928.
- MCDONAGH, J. E. R., F.R.C.S. "The Nature and Treatment of Asthma." *Practitioner*, July, 1929.
- "Asthma and Hay Fever." *Lancet*, August 10, 1929.
- MILES, W. ERNEST, F.R.C.S. "The Problem of Treatment of Cancer of the Rectum in Relation to the Facts of Surgical Pathology." *Report International Conference on Cancer*, London, 1928.
- OKELL, C. C., M.C., M.B., B.Ch., M.R.C.P., D.P.H. (C. J. MONTAGU LAWRENCE, L.M.S.S.A., and C. C. O.). "The Association of Human and Canine Jaundice, with an Illustrative Case." *Lancet*, August 17, 1929.
- PAYNE, REGINALD T., M.B., B.S., F.R.C.S. "Hunterian Lecture on the Treatment of Varicose Veins and Varicose Ulcers by Injection." *Lancet*, August 17th, 1929.
- POWER, Sir D'ARCY, K.B.E., F.R.C.S. "Epoch-making Books on British Surgery. IX The Works of Percivale Pott." *British Journal of Surgery*, July, 1929.
- ROLLESTON, Sir HUMPHRY, Bart., K.C.B., M.D., D.C.L., LL.D., F.R.C.P. "Antagonistic Phases." *Practitioner*, September, 1929.
- ROXBURGH, A. C., M.D., M.R.C.P. "Alopecia Areata." *Clinical Journal*, September 4, 1929.
- SIMPSON, R. H., M.D., M.R.C.P., D.P.H., and BATTEN, LINDSEY W., M.B., M.R.C.P. "Some Points in the Diagnosis of Cardiac Lesions in Children." *Lancet*, August 24, 1929.
- SOUTHAM, A. H., M.D., M.Ch., F.R.C.S. "Mule-Spinners' Cancer." *Report International Conference on Cancer*, London, 1928.
- VERNEY, E. B., F.R.C.P. "The Value of Physiological Tests of Renal Function." *British Medical Journal*, August 3, 1929.
- WALKER, KENNETH M., O.B.E., F.R.C.S. "Chronic Infections of the Urinary Tract." *Clinical Journal*, August 21, 1929.
- WEBER, F. PARKES, M.D., F.R.C.P. "Blood Diseases." *Practitioner*, September, 1929.
- "A Note on Tumours of Endocrine Glands." *British Medical Journal*, September 21, 1929.
- WHITEHEAD, F. E., O.B.E., M.R.C.S., L.R.C.P. "Leprosy in Nyasaland." *Leprosy Notes*, July, 1929.

EXAMINATIONS, ETC.

Royal College of Surgeons of Edinburgh.

The following has been admitted a Fellow: Spackman, W. C.

CHANGES OF ADDRESS.

- ADRIAN, E. D., St. Chad's, Grange Road, Cambridge.
- ANDERSON, H. G., West China Union University, Chengtu, Szechuan, China (*via* Siberia).
- BARNES, W. A., The Shrubbery, Woburn Sands R.S.O., Bucks. (Tel. Woburn Sands 2.)
- BRIGSTOCKE, P. W., The Victoria Hospital, Damascus, Syria.
- CLARK, W. ADAMS, Beaufort, British North Borneo.
- CORBETT, R. S., 29, Dryden Chambers, Oxford Street, W. 1. (Tel. Welbeck 2635.)
- EVANS, E. W. S., 8, Havelock Road, West Marlands, Southampton.
- GLOVER, L. G., 22, Upper Wimpole Street, W. 1. (Tel. Welbeck 0117.)
- MACKENZIE, A. V., 22, Belmont, Shrewsbury.
- NELSON, H. P., 4, Harley Road, N.W. 3.
- POLLARD, Surg.-Lt. E. B., R.N., Royal Naval Hospital, Portland, Dorset.
- ROGERS, K., "Namouna," 25, West Cliff Road, Bournemouth, Hants.
- SKAIFE, W. F., c/o Addington Hospital, P.O. Box 977, Durban, Natal.
- SYMONDS, H., Caledon Street, George, Cape Province, South Africa.
- TAIT, H. B., 68, Southwood Lane, Highgate, N. 6.

APPOINTMENTS.

- BEVAN, F. A., M.B., B.S.(Lond.), appointed Honorary Surgeon to Out-Patients at the Southend Victoria Hospital, Southend-on-Sea.
- BUTTERY, J. W. D., F.R.C.S.E., appointed Honorary Assistant Surgeon to the Royal Victoria Hospital, Folkestone.
- CLARK, W. ADAMS, M.R.C.S., L.R.C.P., appointed Government District Surgeon and Estates Medical Officer at Beaufort, British North Borneo.
- CROOK, E. A., M.Ch.(Oxon.), F.R.C.S., appointed Assistant Surgeon to the Gordon Hospital for Diseases of the Rectum.
- JONES, D. STANLEY, M.R.C.S., L.R.C.P., appointed House Surgeon to the Royal Alexandra Hospital for Sick Children, Brighton.
- SKAIFE, W. F., M.D.(Oxon.), appointed Assistant Medical Superintendent to Addington Hospital, Durban.

BIRTHS.

- BRADFORD.—On August 28th, 1929, at Goodrington, South Devon, to Doris Mary, wife of Ernest Cordley Bradford, M.A., M.B., B.C.(Camb.), of Laneside, Horsham, Sussex—a son.
- JOHNSON.—On September 9th, 1929, at 1, Queenswood Avenue, Wallington, to Margaret, wife of Dr. R. S. Johnson—a son.
- LONGFORD.—On September 12th, 1929, to Elizabeth (*née* Dunn), wife of Dr. W. U. D. Longford, Hollywood, co. Down, Ireland—a son.
- OGIER WARD.—On September 10th, 1929, at 16, Bryanston Mansions, W. 1, to Mr. and Mrs. R. Ogier Ward—a son.
- ROLES.—On September 14th, 1929, at 25D, Fitzjohn's Avenue, Hampstead, N.W. 3, to Joan (*née* Crace-Calvert), wife of Francis C. Roles, M.R.C.P.—a daughter.
- TOPHAM.—On September 4th, 1929, to Dr. Helen Topham, wife of Dr. E. J. E. Topham, 2, West Avenue, Exeter—a daughter.

MARRIAGES.

- ELGOOD—FRANCIS.—On September 9th, 1929, at St. Martin-in-the-Fields, London, John Elgood, M.B., F.R.C.S., elder son of Dr. and Mrs. Elgood, late of Windsor, to Christine Phyllis Francis, M.B., B.S., elder daughter of Mr. and Mrs. J. E. Francis, of the Athenaeum Press, London.
- POWELL—FARADAY.—On September 7th, 1929, at the Church of St. Peter and St. Paul, Aldeburgh, by Canon Goldsmith, assisted by Rev. Danvers and Rev. Snowden Smith, Ronald Rees Powell, M.A., M.R.C.S., Earlsridge, Redhill, to Thelma, daughter of Mr. and Mrs. P. Michael Faraday, Thellusson Lodge, Aldeburgh.

DEATH.

- GIFFARD.—On September 15th, 1929, at a nursing home in Bourne-mouth, Douglas William Giffard, M.R.C.S.(Eng.), L.S.A., formerly of Brighton, aged 81 years.

ACKNOWLEDGMENTS.

The British Journal of Nursing—The British Journal of Venereal Diseases—Bulletin de l'Hôpital Saint-Michel—L'Echo Médical du Nord—Giornale della Reale Società Italiana d'Igiene—Guy's Hospital Gazette—The Hospital Gazette—The Kenya and East African Medical Journal—The Medical Review—The Nursing Times—Porto Rico Review of Public Health and Tropical Medicine—The Post-Graduate Medical Journal—The Queen's Medical Magazine—Revue de Médecine—St. Bartholomew's Hospital Leaflets—The St. Thomas's Hospital Gazette—Sydney University Medical Journal.

NOTICE.

All Communications, Articles, Letters, Notices, or Books for review should be forwarded, accompanied by the name of the sender, to the Editor, ST. BARTHOLOMEW'S HOSPITAL JOURNAL, St. Bartholomew's Hospital, E.C. 1.

The Annual Subscription to the Journal is 7s. 6d., including postage. Subscriptions should be sent to the MANAGER, Mr. G. J. WILLANS, M.B.E., B.A., at the Hospital.

All Communications, financial or otherwise, relative to Advertisements ONLY should be addressed to ADVERTISEMENT MANAGER, The Journal Office, St. Bartholomew's Hospital, E.C. 1. Telephone: City 0510.